**This is a follow-up to the email with Questions & Answers related to the webinar we delivered on the changes proposed in the UMCM and UMCC on April 21, 2017.**

Please submit any remaining questions to HPCS_UMCC_Provisions@hhsc.state.tx.us. Thanks for your partnership.

| | Question | Answer |
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| 1 | Can you please send the website address for the definitions of VBP (APM)? Thanks | HCP-LAN Main Page: https://hcp-lan.org/<br><br>APM Framework one pager: hcp-lan.org/workproducts/apm-whitepaper-onepager.pdf |
| 2 | Will LTSS services be included in the 'medical expenses' in the denominator? | Yes |
| 3 | Are the APM percentage calculated based on each service area and business line or the overall population | The percentages will be calculated by MCO across each program (business line). |
| 4 | How is the minimum target calculated? | The first year's APM targets (1/1/18-12/31/18) were calculated using the most recent deliverables (FY16 period) submitted by the MCOs. Basically we looked at the rough mid-point of where MCOs collectively where in FY16 related to APM expenditures as a starting point. |

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<tr>
<td>5</td>
<td>Is the increase in VBP (APM) total expected to be a 50% increase over baseline or that 50% of our monies are paid in Value Based (APM) Contracts?</td>
<td colspan="3">There are 2 APM targets: 1) Overall APM target (which includes risk and non-risk based APMs) and 2) Risk based APM target.<br><br>Below is the 4 year matrix. For year 4, the targets are : 50% of MCO payments to providers are within an APM model, and 25% of MCO payments to providers are within a risk based APM model
<table>
<tr><th>Period</th><th>Minimum Overall APM Ratio</th><th>Minimum Risk-Based APM Ratio</th></tr>
<tr><td>Year 1 (CY2018)</td><td>>= 25%</td><td>>= 10%</td></tr>
<tr><td>Year 2 (CY2019)</td><td>Year 1 Overall APM Ratio +25%</td><td>Year 1 Risk-Based APM Ratio +25%</td></tr>
<tr><td>Year 3 (CY2020)</td><td>Year 2 Overall APM % + 25%</td><td>Year 2 Risk-Based APM % + 25%</td></tr>
<tr><td>Year 4 (CY2021)</td><td>>= 50%</td><td>>= 25%</td></tr>
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| 6 | If a plan meets the PPA/PPV exception for one Line of Business, but not another, is it possible to receive the exception for that line of business while attempting to meet target in another LOB? | Yes |
| 7 | What measurement year is used for the exception criteria? | Exception criteria: |
| | | **Exceptions to the APM Targets listed in Table** |
| | | If the MCO has already achieved the Year 4 APM Target (CY2021) referenced above, then the required year over year increases are waived. |
| | | If the MCO's actual to expected (A/E) ratio on Potentially Preventable ED Visits (PPV) is <= 0.90 AND the MCO's A/E ratio on Potentially Preventable Hospital Admissions (PPA) is <= 0.90 for the period that aligns with the APM reporting period. The data source for determining A/E ratios will be the monthly Potentially Preventable Events (PPE) reports produced by the External Quality Review Organization (EQRO). |
| | | If a Medicaid/CHIP MCO has been under contract with HHSC for less than one year by September 1, 2017 (SFY 2018), the Year 1 Target represented in Table 1 will be effective in CY 2019, concluding with a Year 4 target in CY 2022. |

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| 8 | Is there a comprehensive document that clearly outlines the expectations of this program? Outside of the contractual change document and the PowerPoint provided today. | Please see attachment 2. |
| 9 | Please repeat the baseline overall and risk based %s. | Please see response #5 |
| 10 | What website did you reference for the framework guide? | Please see response #1 |
| 11 | Please provide the math on how the minimum target will change in year 2 and year 3 | Each year's APM percentage will need to increase by 25% over the previous year. Year 4 percentage is set at 50% overall APM and 25% risk based APM. As you can probably see, increasing 25% each year from the initial year will not get an MCO to the final APM targets. So, each MCO will have to be mindful of the year 4 targets while on this path. |
| 12 | What research is available indicating that Alternative Payment Methods improve outcomes? | As indicated during the webinar, the available research is mixed. This is partly because this is relatively new. What HHSC is trying to do here is follow a recognized national trend in payment reform, but provide the MCOs with the flexibility they need to meet providers where they are at, using data from MCOs to set the initial targets. It is also important to note that there are likely significant differences in impacts on quality and efficiencies between "risk |

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| | | based" APMs and simple "upside only" APMs built on a fee for service payment system. Some links are below this table. |
| 13 | What research is available indicating that providers prefer these types of payment structures? | We haven't located this type of research, but we do know that CMS, thru the various ACO payment models, does have significant take-up by ACOs. We also hear anecdotally that increasing numbers of providers are embracing payment reform as a way to align incentives. Improve outcomes and increase efficiencies. It is also important to note that the payment reform landscape (to include MCO P4Q and provider APMs) should be viewed as an opportunity to improve patient centered care thru rewarding positive performance. One thing that all parties need to be mindful of is keeping administrative complexity as low as possible within this environment. |
| 14 | Will you be sending out this deck? | Yes, this was sent out previously. But it is included again in the email as attachment #1 |
| 15 | Is there an expectation that this will be ready for implementation on 9/1/17? | Yes |
| 16 | Does "gold carding" a provider (waiving pre-authorization, other admin relief) qualifies as VBP/APM? | Yes. Even though there is not a linkage between provider payment and a metric of quality, we recognize that providers value these arrangements in lieu of financial incentives, and so these will be included as an APM. The calculation would include the provider payments as the numerator. |

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| 17 | What category of APMs does the UHRIP payments to providers fall into? | Since they have no linkage to a value metric, pass-through payments made to MCOs by HHSC, and likewise by MCOs to their providers (like in NAIP and UHRIP) should be excluded from the numerator and denominator. They will not be considered part of the APMs. |

Not a webinar question, but recently received from TAHP and TACHP

Question: **LD for Value-based Purchasing arrangements**: These new requirements need more discussion. MCOs are the leaders in forging value-based relationships, but providers in a state as vast as Texas are often not able or willing to enter into alternative payment contracts. Depending on how these targets are defined and how an MCO's baseline is determined, MCOs could be financially penalized while, at the same time, jeopardizing long-standing relationships with providers.

Response: We believe that the response to this concern is within the responses above and attachments.

MISC. LINKS:

http://annals.org/aim/article/2596395/effects-pay-performance-programs-health-health-care-use-processes-care.

http://healthaffairs.org/blog/2014/03/04/the-payment-reform-landscape-pay-for-performance/.

https://www.cdc.gov/pcd/issues/2016/16_0133.htm.

http://www.rand.org/content/dam/rand/pubs/research_reports/RR300/RR306/RAND_RR306.pdf.

https://blogs.sph.harvard.edu/ashish-jha/2013/02/04/getting-pay-for-performance-right/